

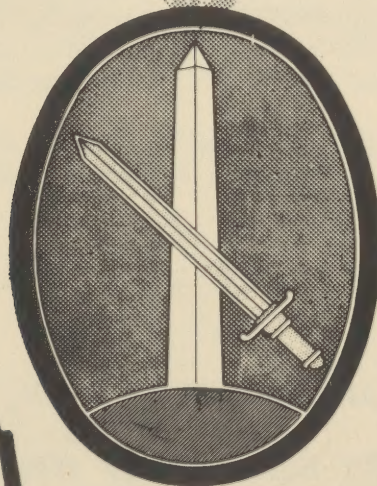
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REPORT NO.10

RESTRICTED

MONTHLY HEALTH REPORT

Military District of Washington



RESTRICTED

October 1951



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This "Monthly Health Bulletin" invites every reader to participate in its preparation by contributing articles. There must be something in the daily military experiences that will interest others and possibly be helpful to others. Administrative directives, professional articles, clinical notes, descriptions of new devices and instruments are welcomed. While the number of copies of this publication is not great, there is a wide distribution, geographically speaking.

Contributions should be addressed to The Surgeon, MDW, Room 2D-201, The Pentagon, Washington 25, D. C.



MAJOR GENERAL THOMAS W. HERREN
COMMANDING
MILITARY DISTRICT OF WASHINGTON
Room 1543, Building T-7, Gravelly Point
Washington 25, D. C.



INTRODUCTION

This publication presents periodic health data concerning personnel of the Department of the Army in the Military District of Washington. It provides factual information for measurement of increase or decrease in the frequency of disease and injury occurring at each of the posts, camps or stations shown herein.

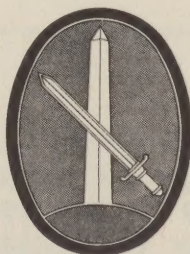
It is published monthly by the Military District of Washington for the purpose of conveying to personnel in the field current information on the health of the various military installations in this area and on matters of administrative and technical interest. Items published herein do not modify or rescind official directives, nor will they be used as a basis for requisitioning supplies or equipment.

Contributions; as well as suggested topics for discussion, are solicited from Army Medical Service personnel in the field.

ROBERT E. BITNER
Colonel, MC
Surgeon

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NEW COMMANDING OFFICER, U. S. ARMY DISPENSARY,
FORT MYER, VA.



Colonel Charles C. Canada, Medical Corps, is a native of Stanton, Virginia, where he received his early education. He is a graduate of the University of Virginia and received his MD in 1931. In 1933 he was appointed 1st Lieutenant, Medical Corps Reserve, and practiced medicine in Arlington, Virginia, for many years.

He married Miss Ruth Hooper of Arlington, Virginia, in 1937, and they have one son, Charles C. Jr., age eleven years.

In early 1943 Colonel Canada was assigned to the 38th General Hospital, North Africa. Following his return to the United States in 1945, he was assigned to the General Dispensary, Pentagon, Washington, D. C., and in 1947 was ordered to the Far East Command as Personal Physician to General of the Army Douglas MacArthur. In addition, he administered and supervised medical treatment for members of the Imperial family, and to the ranking emissaries of the other occupation countries.

Among the numerous awards and decorations received by Colonel Canada are: The Silver Star, The Air Medal, The European Africa and Middle East Medal, and many others, the more recent being the "Legion of Merit", awarded for exceptionally meritorious service in the Far East Command, during the period 25 June 1950 to 16 April 1951.

On 1 August 1951 Colonel Canada was assigned to Fort Myer, Virginia, as Post Surgeon and Commanding Officer of the U. S. Army Dispensary. This Dispensary is one of the largest and busiest Dispensaries in the Army, with a military and dependent population of 35,000 to 40,000 people eligible for treatment.

In the short time he has been on duty at Fort Myer, Colonel Canada has demonstrated his remarkable professional skill, and has contributed considerably to the morale and efficient operation of this Installation.

Colonel Canada is now supervising the completion of construction work for expansion and improvement of the Fort Myer Dispensary. This will relieve crowded waiting rooms, expedite the registration of patients, provide adequate examining room space, eliminate patients being referred to separate buildings, etc., as well as improving the general appearance of the Dispensary.

PREVENTIVE MEDICINE

CONTROL OF RESPIRATORY DISEASE

By
Colonel Robert E. Bitner, M.C.
Surgeon, Military District of Washington

During the winter months, respiratory diseases cause a large non-effective rate in the Army. The control of these diseases, particularly the common cold, is not only difficult, but usually very non-productive of results. Our modern living habits contribute to the spread of these diseases. Such conditions as congestion, overheating of rooms, low humidity, improper ventilation, improper dress, appear to be important factors in the transmissibility of these diseases from one person to another. While the causative agents (bacteria or virus) are known in some of the respiratory diseases, such is not the case of the common cold. Much investigative work has been done on the common cold, but we appear to be as far as ever from learning its causative agent.

Certain factors in the control of respiratory disease are important if enforced:

- a. Proper spacing of beds. There should be at least five feet of space between beds if conditions will permit. If local conditions require closer spacing a shelter half or similar screen can be placed at the side of the head of each bed. This will amount to an improvised cubicle. This is preferable to head to foot arrangement. It is even preferable to double decking since the level of air is the same for all, and there is the avoidance of disturbing the other sleeper.
- b. Avoidance of crowding in classrooms, and like assembly places.
- c. Removal of mess personnel who have respiratory disease.
- d. Education of all personnel in the matter of covering mouth and nose when sneezing, or coughing. Spitting must be prohibited.
- e. Ventilation of all rooms, particularly sleeping quarters.
- f. Control of humidity. This can be accomplished by reducing temperature, good ventilation, and in homes by humidifiers, either the elaborate commercial types or simple pans of water.
- g. Discipline in sweeping floors, and making of beds. Dry sweeping must be avoided. Of course under ideal conditions there will be some dust so this might be an excellent time to have gas mask drill.
- h. Proper clothing should be worn to fit the temperature and humidity. Avoidance of perspiration and chilling subsequently is essential.

There are specifics for some of the respiratory diseases. The prescribing of these must necessarily be up to medical personnel. There is no specific for the common cold. Antihistaminics so well advertised in 1950, have lost their popularity because of their non-effectiveness. Antibiotics (penicillin, aureomycin, terramycin, chloromycetin) are non-effective in addition to being wasteful from a cost factor. However, sensible living in the matter of extra rest, moderate diet, proper water intake are essential. Add to that steam inhalations, and simple medications and we have about all that can be done presently for the modern cold. Future investigation, we hope, will be productive of some specific.

* * * * *

Attention is called to the article "Approved Examining Boards in Medical Specialties", Page 476, J.A.M.A. September 29, 1951.

This is an exhaustive article covering requirements and credit allowances for the various Specialty Boards.

PREVENTIVE MEDICINE

THE PLACE OF SALINE IN TREATMENT OF INJURIES WITH SHOCK

By

Dr. Dickinson W. Richards, Jr.
Prof. of Medicine, Coll. of Phy. & Surg.
Bellevue Hospital, New York City, N. Y.

I. Saline for parenteral administration.

The proper place of intravenous saline in the treatment of injured persons in shock can be adequately defined on the basis of existing knowledge.

A large amount of work has been done on this problem, over many years, both experimentally, clinically, and in battle casualties during World War II. While certain questions remain unanswered, and some differences of opinion persist, it is believed that a general statement can be made to which most authorities, if not all, will agree, and which will permit appropriate action to be taken by the Armed Forces and Civilian Defense agencies, for procuring and stockpiling these solutions.

The function of saline as an element in the bodily economy is essentially kinetic and not static; saline tends to move through the body rather than remain in it. Normally a salt solution, after intravenous administration, is rapidly distributed through the body fluids, and then rapidly excreted through the kidneys.

In the presence of dehydration, blood loss, and other conditions where there is a net loss of tissue fluid, additional salt and water is needed for replacement over and above that required for urinary excretion. The same applies to conditions in which extra fluid accumulates in tissues, as in the edema of burns, crush injury, infection, and the like. Sweating also uses up electrolytes and water. When these volumes are satisfied, again the basic need for added salt and water is for purposes of urinary excretion.

In acute shock, when blood or plasma is not available, intravenous saline, rapidly administered, can frequently restore and sustain the circulation for brief periods. After one liter or two liters of intravenous saline, a significant increase in plasma volume will be maintained for perhaps an hour or two, as compared with 12 to 24 hours when blood or plasma has been given. Saline is also helpful in maintaining patency of vein, needle, and tubing, between transfusions. Additional saline has a special place in burns, for the reasons above described.

In the general scheme of therapy, saline is a complement to blood or plasma, and not a substitute for them. Parenterally administered saline is needed (1) to provide salt and water for dehydrated tissue depots, (2) to provide salt and water for essential urine volume, in all instances where the injured person cannot take sufficient food, electrolytes and water by mouth for these purposes. The basic criterion for saline requirement is urine volume, not plasma volume. In one clinical situation blood may be needed, and saline not needed at all; in another clinical situation, saline may be required for days or even weeks after the need for blood has passed. In still other situations, glucose and water may be indicated, rather than saline.

From the above, it is apparent that the use of parenteral saline is an essential part of the treatment of the injured person in shock; separate from, but complementary to, the use of blood, plasma, or plasma substitute.

This Committee therefore recommends to The Armed Forces and Civilian Defense the procurement of saline solutions suitable for parenteral administration, for the treatment of wounds and burns, over and above, and separate from, the necessary supplies of blood, plasma, and plasma substitutes.

II. Oral saline.

As indicated in the preceding discussion, since saline is chiefly needed to supply tissue depots and to provide for urine volume, saline by mouth, if it can be retained and absorbed, should be as effective as saline by vein. As supplementary and continuation therapy, therefore, in patients who are in condition to tolerate it, oral saline will be of value. It will be of special usefulness

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in burns, of moderate severity or extent, where the patient is not in severe shock, but where the requirement for additional salt and water is large.

On the other hand, it must be emphasized that oral saline, like all other measures, must be administered only upon physicians' orders. Indiscriminately used, especially if given to those in severe shock, oral saline can do great harm, as for example: (1) through vomiting, with additional loss of salt and fluid; (2) through vomiting and aspiration, with the risk of aspiration pneumonia, or of immediate asphyxial death; (3) in abdominal injuries; (4) when there is, for any reason, a tendency to pulmonary edema.

With the above reservations, measures which will provide oral saline for injured persons who are either not in shock or are in mild shock only, are recommended to the Armed Forces and to Civilian Defense.

USE OF SALINE SOLUTIONS IN INJURIES WITH SHOCK

I. Parenteral (intravenous) saline, isotonic: NaCl and glucose, NaCl and NaHCO₃, Na lactate, Ringer, Ringer-lactate, etc.

1. Indications.

(a) Dehydration: saline solutions clearly indicated, may provide complete relief of condition. Amounts, 1 to 3 liters, sometimes much more in severe dehydration, as in diabetic acidosis, cholera, etc.

(b) Shock due to or associated with massive blood loss. Useful as supplement to plasma or blood, especially if there is added dehydration; or to sustain circulation for $\frac{1}{2}$ to 1 hour while blood or plasma is being obtained. One to 2 liters saline can maintain some increase in blood volume and cardiac output for 1 to 2 hours. Too much intravenous saline may overhydrate tissues, will eventually lead to venous congestion and pulmonary edema. Plasma protein levels will give indications of overhydration.

(c) Shock due to burns. Saline in large amounts up to 3 or 4 liters daily, may be useful, as supplement to blood or plasma, in extensive second and third degree burns, during first 36 hours after injury. Caution after 36 hours, as there is risk of circulatory congestion and pulmonary edema.

(d) Continuation therapy. When water and electrolytes cannot be taken by mouth in quantities sufficient to maintain urinary volume at normal or adequate levels, additional parenterally administered saline may be indicated.

2. Contraindications.

(a) Congestive heart failure (venous congestion, pulmonary and peripheral edema).

(b) Chest injuries (pulmonary edema).

(c) Burns involving tracheobronchial tree or lungs (pulmonary edema).

(d) Renal shutdown, except where actually due to dehydration or existing shock.

II. Oral saline. (Chilled isotonic or slightly hypotonic salt and sodium bicarbonate solution, or one-sixth molar sodium lactate, is more palatable than isotonic sodium chloride).

1. Indications.

(a) Dehydration, when and if tolerated by GI tract.

(b) Injuries with mild shock. One to 3 liters daily, to relieve thirst and provide fluid and salt.

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(c) Mild to moderate burns. If parenteral fluids are not available, saline, preferably chilled, can be taken by mouth in amounts up to 2 to 3 liters daily, providing patient's general condition is fairly good, and there is no risk of aspirating vomitus. Patients sometimes vomit oral saline at first, but subsequently are able to retain it.

2. Contraindications.

- (a) Severe shock or poor clinical condition with risk of vomiting and aspiration.
- (b) Abdominal injuries.
- (c) Inability to retain oral fluids.
- (d) Renal shutdown, not due to dehydration or existing shock.

* * * * *

IMMEDIATE CARE AND FOLLOW-UP OF BURNS IN THE FIELD

By

Harry L. Bibber, Sergeant First Class, Medical Service, U. S. A.

Patients with second and third degree burns in the field are frequently first seen by medical aid men on independent duty and the first treatment is often given by them. These burns are usually grossly contaminated and aseptic conditions for dressing the burned areas are frequently unavailable. As a member of a small battalion medical detachment, often providing the only medical facilities within a 50 mile radius, I have treated many second and third degree burns following some to complete recovery.....

The cases reported illustrate the fact that that which is often taught as first aid for burns is frequently not applicable and even detrimental to recovery and the prevention of infection.

Speaking of treatment of burns in advanced positions in the field a low rate of infection, minimum loss of body fluids, and rapid recovery depend on the relatively simple procedures of: (1) cleansing the wound with warm, soapy water and irrigating with clean water, if necessary; (2) keeping to a minimum the delay between the time of injury and the time the injured surfaces are protected; (3) using clean, dry materials for dressings when sterile supplies are not available; (4) the immediate use of antibiotics to prevent or inhibit infection; and (5) allowing the dressings to remain undisturbed as long as possible, usually from 7 to 10 days.

Because the consequences of infection in a burn usually by-pass the aid man and become the problem for medical personnel at rearward echelons of evacuation, it is believed that greater use of the above procedures by the field aid man not only will render greater service to the patient but also ease the burdens of those who often have to undo what has been done by a well-meaning but ill-advised field medic.

(The above is from Medical Technicians Bulletin, September-October 1951, Vol. 2, No. 5.)

* * * * *

The average G. P. is 41 years old and sees 25 patients during a working day of 11 hours. Five hours a week he works "for free" and 28 days each year he spends attending the postgraduate courses, medical meetings and hospital staff conferences. He delivers 44 babies a year. And he practices in a city of 50,000 to 100,000 population.

This picture is based on a sampling of members of the American Academy of General Practice, as reported by Dr. Stanley R. Truman, U. Calif. '34, retiring Academy president.

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BLOOD IS NEEDED

Colonel Robert E. Bitner, M.C.
Surgeon, Military District of Washington

Blood is now more urgently needed than at any previous time: to replenish the waning reserve of plasma, to meet the needs of the Armed Forces, both in Korea and elsewhere, and to meet local civilian needs throughout the country.

The American Red Cross has been designated as the responsible collecting agency. Armed Forces collection centers have been established to assist in this program, primarily to aid in the collection of blood for plasma. Every assistance should be given all the way along the line towards aiding in this program. What can be done? Encourage persons to give blood; give blood yourself; know where the blood donor centers are and when they operate. Further the publicity campaigns through every medium available; post papers, church bulletins, lodge bulletins and similar publications can be used, and above all, by word of mouth encouragement and urging of family, friends and acquaintances.

General Ridgway has said "Every American who has given blood can and should feel that he personally has contributed directly to the saving of the life of an American boy". Yes, the blood spilled on the battlefield can now be replaced if the American people desire to do it. So effective is this replacement that the mortality figure for the wounded has dropped from 4.5 per hundred wounded in World War II to 2.6 per hundred in the Korea action. How different these figures are from World War I when 8 to 11 out of every hundred wounded men died.

The campaign is on. Here are a few points to remember:

Any person in good health from 21 to 59 may donate blood every two months. Five donations in a calendar year is the maximum recommended.

Whole blood can be preserved for only 21 days.

It requires 2.4 pints of whole blood to make one pint of plasma.

The Armed Forces require 3,000,000 pints of blood for plasma by July 1952.

Everyone will benefit by adequate reserves.

No harm results from the withdrawal of a pint of blood.

It costs no money to give a pint of blood.

The campaign for blood is on now. Everyone should assist to his fullest ability, as a manifestation of his willingness to support and maintain this country and the American way of life.

* * * * *

PRE-MARITAL BLOOD TESTS FOR ARMY PERSONNEL

Information has been received by the Department of Defense that in certain instances State legal requirements are not being fully satisfied pertaining to the reporting of pre-marital blood tests accomplished at Army medical treatment facilities. Some States require that the results of blood tests be submitted on forms issued by them, while others also make it obligatory that the tests be performed within the State issuing the marriage license.

It is the responsibility of the individual requesting the blood test to determine the State requirements and to furnish the commanding officer of the Army medical treatment facility concerned with any reporting forms required under the laws of the State in which marriage is contemplated. State forms required for this purpose will not be supplied by the Army.

(The above is from D/A Circular 71, dated 30 August 1951)

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WALTER REED ARMY MEDICAL CENTER, WASHINGTON, D.C. - September 25, 1951

Press-O-Jet injector developed at Walter Reed Army Medical Center is being used by 1/Lt. Philip Y. Paterson to inject SFC Wallace Fee. The injector was developed in the Virus & Rickettsial Diseases Department of the Army Medical Service Graduate School, a component of the Walter Reed Army Medical Center.

JET INJECTION MAY REPLACE NEEDLE

A multiple-dose high-pressure jet injection apparatus now being tested at the Army Medical Center offers eventual rapid inoculation of large numbers of people against disease.

Resembling an automatic pistol in size and shape, the jet apparatus requires no special training for handling. Its use alleviates possible danger of infection caused by using the hypodermic needle and eliminates sterilization of equipment.

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THE PLAGUE, STILL A DANGER

By

John M. Gibson, Director
Division of Public Health Education
State of Alabama

We like to think of certain diseases as belonging definitely to the past. They were terrible before they were conquered, we say to ourselves, but we don't have to pay any attention to them any more.

But we cannot be so sure about that. It is by no means certain that the peril those illnesses brought has been dispelled for good and all. Unless we--all of us--are constantly alert, constantly watchful, they may awake with an awful burst of death, disease and devastation.

The plague is a case in point. Few of us ever give it any serious thought, except as an item in history. The fearful conditions it created in many parts of the world will never be seen again, at least in civilized countries like this one, we assure ourselves comfortingly.

But are we sure? Can we be sure?

You may be surprised to be told that cases of the plague have been reported recently. You may be even more surprised to find that cases are by no means rare in our own country.

As recently as last August 24, the newspapers and the radio announced that 12 cases of bubonic plague had been reported from three different villages in Southwest Arabia. The World Health Organization, WHO to most of us, immediately sent one of its top experts to look into the situation and launch whatever steps might be called for.

Cases which have been found closer home--much closer--showed up in the Southwest and Western United States. They were reported in the fall of 1950 by the Journal of the American Medical Association. A press release issued by the A.M.A. to call attention to the Journal article declared: "An unusual number of isolated cases of plague, the Black Death of medieval times, which have occurred in New Mexico and other southwestern and western states during the last year warn that conditions are favorable for an outbreak of the disease."

"Unless plague is suspected, diagnosed and treated early, sooner or later a case will occur in which a pathologic pulmonary condition will develop and initiate a pneumonic outbreak with far more serious loss of life than generally occurs from the sporadic occurrence of single bubonic cases."

Dr. Link's A.M.A. Journal article went on:

"Five cases of plague occurred in New Mexico from July, 1949, through July, 1950. Eight additional suspected cases have been observed during the same period in California, Montana, Nevada, New Mexico, Texas and Utah. These totals are considerably above previous averages. They should serve as potent warnings to physicians to consider plague in diagnosis.

"Plague-infected wild animals have been found in over half the counties of New Mexico and it is not surprising that five human cases have occurred during the past 12 months."

Fortunately, medical science is much better prepared to deal with the plague when it strikes than it used to be. Most effective of the drugs that have been developed in recent years are streptomycin and sulfadiazine. With reasonable alertness, the public health agencies and private physicians should be able to keep a plague outbreak within fairly moderate limits. But the danger is a real one.

This is a disease with a dark and somewhat mysterious history. Greek physicians of the second and third centuries B.C. left to their medical posterity records of a form of illness which is believed to have been the plague. It is described as having been prevalent in Syria, Egypt and Libya. Somewhat later, two men of medicine practicing their profession in Alexandria during the lifetime of Christ, left a description of a form of illness which, in the words of Surgeon General George M. Sternberg, of the Army, "leaves no doubt as to its identity with the plague of more recent times." The most striking parts of both descriptions mentioned their references to what are known in medical circles as buboes. These consist of enlarged and inflamed glands in the groins, in the

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arm pits and elsewhere on the body. In chronic form, these contain and discharge a virulent pus, which transmits the disease to others.

There are scanty and in fact virtually non-existent records of this disease's prevalence from the first through the fifth centuries after Christ. However, this does not mean there were no cases. For, remember, communications of all kinds were most primitive at that time. We would probably be entirely correct in saying that a considerable number of cases existed but hardly any records were made of them.

However, there are numerous records of the disease in the sixth century. Indeed cases appear to have occurred with devastating intensity in many parts of the Roman Empire, or even beyond. This particular epidemic, which continued for more than half a century, is believed to have begun in lower Egypt. It is supposed to have started its rapid march over much of the civilized world in the year 542. It moved, like a pestilential cloud, along the northern coast of Africa in one direction. In another direction, it traveled toward and into Syria and Palestine. The following year that movement of death invaded the European continent. Few invasions by enemy armies have had as much to do with the well-being of the people of that troubled continent. During the first year and for several years thereafter many communities were laid waste. Towns were depopulated. In the interest of complete truth, however, it should be pointed out that possibly, indeed quite possibly, this work of wholesale killing and laying waste of countrysides was assisted substantially by other illnesses of an infectious nature.

Later there were epidemics in various parts of Europe, although here again the records are rather scanty. Then, near the mid-point of the fourteenth century, the frightful disease known at the time and since as the Black Death fully lived up to its name. So devastating was its sweep that it is said to have killed no fewer than 25 million people. (That is about a sixth of the present population of the United States).

It is true that all medical authorities are not agreed that the plague and the Black Death are, and were, exactly the same. But even the relatively few who do not consider them identical agree that they are essentially one.

London apparently had its first encounter with these diseases in November, 1348. There were epidemics in other parts of the country over a period of eight or nine years. In 1352 Oxford was so severely struck that two out of three of the famous university's academic staff succumbed. Later epidemics appeared here and there in the British Isles in 1361 and 1368. So heavy was the loss of lives in certain sections that it was impossible to cultivate the land. The few farm laborers who survived or moved into the devastated areas afterwards were able to demand and get high wages.

In an address delivered at Georgetown University in 1900, Dr. Sternberg quoted from a description of this outbreak. He did not identify the author, referring to him only as "a writer of the period." This is what that "writer of the period" had to say about this disease-produced conflagration:

"Wild places were sought for shelter; some went into ships and anchored themselves far off on the waters. But the angel that was pouring the vial had a foot on the sea as well as on the dry land. No place was so wild that the plague did not visit--none so secret that the quick-sighted pestilence did not discover--none could fly that it did not overtake. For a while all commerce was in coffins and shrouds, but even that ended. Shrift there was none; churches and chapels were open, but neither priests nor penitents entered--all went to the charnel-house. The sexton and the physician were cast into the same deep and wide grave; the testator, and his heirs and executors were hurled from the same cart in the same hole together. Fire became extinguished, as if the elements had expired, and the seams of the sailorless ships yawned to the sun. Though doors were opened and coffers watched, there was no theft; all offenses ceased, and no cry but the universal woe of the pestilence was heard among men."

The plague maintained its reign of death and devastation throughout much of Europe and in the British Isles in the 15th and 16th and 17th centuries. Fairly large areas enjoyed brief escapes from its visitations, but the terror it brought remained long after it took its temporary departures. The disease killed 38,000 in London alone in 1603, but that city's greatest trial by plague was still to come. It came in 1665, after a few years of relative, if not absolute, freedom from the scourge.

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Striking with renewed fury, it brought death to 68,596 Londoners in a few months. As the city then had a population of only 460,000, this meant that more than one-seventh of its people were killed. Even this ratio fails to tell the complete story of the epidemic's toll. For, as people had been doing for centuries and would continue to do for additional centuries, a large proportion of London's inhabitants fled in terror from the besieged city. How many did so, we have no means of knowing. But probably it would be no exaggeration to say that, of those who were actually in the city during those terrifying months, one out of every five was killed.

Like other epidemic diseases, the plague is transmitted by a minute organism. It eluded science for centuries, which largely explains why those epidemics were never successfully challenged until near the end of the nineteenth century. But in 1894 the Japanese bacteriologist Kitasato, a former pupil of the Famous Dr. Robert Koch, revealed it. By one of those scientific coincidences which occur from time to time, the same discovery was made at almost the same time by another bacteriologist half-way around the world, the Frenchman Yersin. As a result of that valuable two-time addition to medical science's store of knowledge, progress went forward fairly rapidly. It was soon revealed that certain animals, including rats, mice and squirrels, are quite susceptible to infection. About the same time, or perhaps a little later, it was learned that these tiny organisms are present not only in the blood and in pus discharged from the bodies of humans and animals having the disease but also in the excreta, or body wastes.

The same general conditions which favor other epidemic diseases play their tragic part in the plague. Perhaps the most powerful of them are filth, famine and overcrowding. Such conditions, unfortunately, are the usual aftermaths of war, especially in war-devastated countries.

That is a sobering thought as we contemplate the ravages of the Second World War and the desolation left by advancing and retreating armies in tortured Korea. But our physicians and public health workers are awake to this danger. Thanks to them and to the instruments of health-protection their professional ancestors have placed in their hands, probably there is no occasion for great anxiety. Nevertheless, all should be aware of the danger. All of us should be prepared for possible outbreaks here and there in the world.

(The above is a Radio talk tape-recorded as of September 6, 1951 for broadcasting by cooperating stations. State Dept. of Health, Div. of Public Health Education, Montgomery 4, Alabama)

ADMINISTRATIVE SERVICE

ARMY EXTENSION COURSES

Reference is made to AR 350-300, SR 350-300-1, and DA Pamphlet No. 20-100.

Analysis of the records of enrollment maintained by the Department of Extension Courses at the Medical Field Service School, Fort Sam Houston, Texas, indicates that members of the Army Medical Service are not taking advantage of the opportunities afforded by this excellent system of non-resident instruction. This fact is evident when current enrollments are considered in relation to the enrollment potential existent at this time. The referenced enrollment potential is considered to include not only the members of the civilian components on an inactive duty status but also all individuals on an active duty status.

In view of the evident disparity between actual enrollment and the enrollment potential of Army Medical Service personnel, it is desired that all commanders and their subordinates of Class II Medical Service installations and activities initiate action to stimulate interest in the Army Extension Courses among all Army Medical Service personnel. This action is deemed essential and necessary in order that the greatest number of personnel can participate in this excellent means of self-instruction, thus improving their military knowledge and capabilities.

It is desired that this information be disseminated to all personnel and given the utmost publicity.

(The above is from SGO Circular No. 156, dated 17 September 1951)

ADMINISTRATIVE SERVICE

MEDICAL SUPPLY NONSTANDARD ITEMS AND SERVICES

By
Major R. E. Cross, MSC
Med. Sup. Off., USA Disp, The Pentagon

DEFINITIONS:

The term "procurement" includes, by way of description and without limitation, purchasing, renting, leasing or otherwise obtaining supplies or services.

"Standard" items are those listed in the Armed Services Catalog of Medical Materiel.

"Nonstandard" items are medicinal agents and supplies not listed in the above cited catalog and which are not the supply responsibility of another technical service of the Army.

PROCUREMENT:

The Armed Services Catalog of Medical Materiel has been designed to include all medical supplies and equipment regularly furnished medical activities to meet the ordinary requirements of these activities. Such standard items are normally obtained by a centralized procurement agency known as the Armed Services Medical Procurement Agency. As a result of procurement actions of the foregoing agency, medical supplies which have been standardized continually flow into depots for subsequent distribution to stations. Occasions arise however, whereby using activities require medical items in addition to those listed in the above cited catalog. Funds to cover procurement of non-standard medical items and local repair services are established for the Army by the Surgeon General's Office, Department of the Army. The amount of monetary credits for each station is determined by the Surgeon General for each fiscal year and the funds are made available to stations through the distribution depot. Usually these funds are allotted on a quarterly basis and the indicated amounts may not be exceeded without approval of a request for an increase in the allotment.

Nonstandard medical items or repair services to be charged against the monetary credits established for the station can be obtained by one of the following methods:

(1) STATION PURCHASE WITHOUT PRIOR DEPOT APPROVAL.

Procurement without depot approval is effected at station level for small quantities of nonstandard, nonrecurring expendable supplies or contractual services and within the limitations of the current monetary credits. A confirming requisition must be forwarded to the depot.

(2) DEPOT APPROVED STATION PROCUREMENT.

All station procurement of nonstandard medical supplies, equipment and/or repairs, with the exception of Emergency Purchases under AR 40-1705, or as outlined in the preceding paragraph, requires prior approval of the depot.

(3) DEPOT PROCUREMENT FOR STATION.

In some instances, procurement of nonstandard items requisitioned by stations will be accomplished at the depot level for direct shipment from the vendor to the station.

EMERGENCY PURCHASE: (AR 40-1705)

Emergency purchase of small quantities of standard or nonstandard medical supplies may be made to save life or prevent suffering and distress. Prior depot approval is not required nor will the cost of such purchases be charged against the station monetary credits. The Commanding Officer or Surgeon approving the emergency purchase is required to sign a certificate on the purchase order as follows:

"I certify that items procured by this order were necessary to save life or prevent suffering and distress in the treatment of military personnel or others entitled to treatment."

ADMINISTRATIVE SERVICE

RESTRICTIONS:

(1) THERAPEUTIC AGENTS BOARD.

The Surgeon General Directed in Circular No. 2, Part III, dated 4 January 1950 that a board of officers, to be known as the Therapeutics Agents Board be appointed at stations for the purpose of making periodic recommendations relative to the local purchase of nonstandard drugs and biologicals. It is the responsibility of this board to review each request for a nonstandard drug or biological and recommend approval or disapproval, based on consideration of the availability and efficacy of a standard product and the therapeutic superiority of another product which might make justifiable the substitution of, or selection of a nonstandard item.

(2) STANDARDS FOR MEDICINAL AGENTS. (AR 40-507)

No medicinal agent which has not first met one or more of the following conditions will be administered to patients under the care of the Medical Department of the United States Army:

(a) Inclusion in the Armed Services Catalog of Medical Materiel.

(b) Inclusion in the United States Pharmacopoeia.

(c) Inclusion in the National Formulary.

(d) Acceptance by the Council on Pharmacy and Chemistry of the American Medical Association (inclusion in "New and Nonofficial Remedies" or its interim supplements.)

(e) Acceptance by the Council on Dental Therapeutics of the American Dental Association.

(f) Specific approval of the Surgeon General or of the appropriate overseas command surgeon.

* * * * *

NEW RED BLOOD CELL COUNTER

A red blood cell counter which has certain advantages over the present visual method employed by technicians has been developed under a contract of the Physiology Branch, Office of Naval Research, with Cornell University. Red blood cell counts are required in routine hospital examinations, in the screening of men for military service, and in estimating damage due to hemorrhage, shock, thermal burn, and exposure to ionizing radiations. Under war conditions the number of counts which must be made increases a thousandfold. It is under such conditions of mass counting that the counter appears to be most satisfactory and promises to save valuable time for medical technicians, but its use is not practical when only a few samples must be counted. With a slightly modified unit, 3 persons could probably perform from 40 to 60 counts per hour. This counter which is based on a relationship between the red cell count and the conductivity of whole blood is most useful, at present, for making blood counts of normal persons.

Errors of the visual methods such as those of the chamber, pipette, a microscopic field are not encountered in the conductivity method because there is no dilution and the quantity of blood is not critical, but although one method may avoid errors occurring in other technics, each method has errors peculiar to itself. In the most recent testing of the instrument which was carried out at the Microbiology Institute, National Institutes of Health, Bethesda, Md., the average counting error was about 9 percent.

(The above is from Medical Technicians Bulletin, Vol. 2, No. 5, September-October 1951)

ADMINISTRATIVE SERVICE

THE OVERALL EFFICIENCY INDEX

The Problem

Scores on single efficiency reports fluctuate widely. Each report represents the opinion of one rater, reviewed by an indorser. Fluctuation of scores in the rule, rather than the exception. Even raters observing the same performance at the same time often disagree in evaluating it. Too often the efficiency report is a reflection of the rater, rather than an evaluation of the performance of the rated officer. The difference between "easy" and "hard" raters is one of the typical causes of fluctuation in efficiency report score.

The Overall Efficiency Index

To lessen unfair effects of this problem the Army has adopted the Overall Efficiency Index. This index, abbreviated OEI, is an average of the most recent efficiency ratings rendered on a particular officer. The averaging method was used by the Army prior to World War II and was found to be the best estimate of efficiency when raters have disagreement as to the worth of a subordinate.

At a maximum, the OEI covers five years of service. However, the index is computed for lesser periods of service, being calculated on the basis of whatever scores are available. Each index considers the length of duty time upon which the single report is based.

What Reports are Used

Only regular efficiency reports are used in calculating the Overall Efficiency Index. Academic, letter, or abbreviated reports although an important part of an officer's efficiency report file, are not used.

No score issued before 1 July 1947 will be included in calculating OEI. Each new reporting year, the scores for that year are included in the computation. The OEI is a moving average score which covers only the efficiency reports for the most recent five years.

Because of school and other assignments for which scored reports are not rendered, the OEI for an individual officer will seldom be based on a full five year's performance. The amount of duty time upon which the OEI is based, is always presented with the index itself.

How OEI is Computed

Since 1 July 1947, all efficiency scores have been reported by using the Army Standard Rating (A.S.R.) system. Scores under this system range from a low of 51 to a high of 150, with 100 representing the middle score. The OEI uses this same standard scoring system.

At the end of each reporting year (now 31 May), the numerical scores of each officer's efficiency reports for recent years are assembled. The scores are averaged, taking into account the amount of duty time on which each report is based. The average scores on all Army officers are then arranged from the lowest to the highest, and the middle score assigned a value of 100. Working systematically from this mid-point, the average scores are assigned values from 51 to 150. The relative positions of officers in the service is in no way altered by this procedure.

Interpreting the OEI

The index allows comparison of an officer with other officers in the Army during a particular year, or over a series of years. To meaning of an OEI is always relative to the entire population of Army officers. It carries no implication about the number of officers who can be considered competent or incompetent.

The OEI's are so developed that two-thirds of the officers will have scores between 80 and 120; one-sixth will exceed 120 and one-sixth will fall below 80. This pattern of scores will hold true for every year, making it possible to have a consistent interpretation of the OEI, even though the rating forms may be changed.

ADMINISTRATIVE SERVICE

The OEI, in comparison with a series of fluctuating single scores, gives a more accurate and fair appraisal of an officer's relative efficiency. When considered with other available information, the index makes possible more effective personnel action.

VETERINARY SERVICE

PARASITES IN FISH

"Parasitic Infestation of Seafoods: At the present time there are no parasites which may be found in seafoods purchased by the Armed Forces which are harmful; their only importance is that their presence is undesirable from an aesthetic viewpoint. There are two parasites found in fish in this area which are present in sufficient numbers to be of significance. These are *Porracaeum decipiens* or 'codworm' found in codfish and some species of flounders and *Sphyrion lumpi* (called 'button' by the trade), the copepod found mainly in the ocean perch or redfish. From all available information the occurrence of parasites in haddock is rare.

Porracaeum decipiens (codworm or roundworm)

"This parasite is a relatively large roundworm ranging in color from white to reddish-brown, and in length from one to eight centimeters. It belongs in the genus *Ascaris*, sub-family Anisakine. It is a larval form as found in fish which act as intermediate hosts; the definitive host being the harbor seal. The mature worm deposits eggs in the intestinal tract of the seal; these eggs pass out in the droppings and hatch in sea water into small larvae less than one-hundredth of an inch in length. These larvae are swallowed by some invertebrates (shrimp) which are in turn eaten by the fish in which the larvae penetrates into the musculature and develop into the form which we know as the 'codworm'. The fish purchased by Armed Forces in which this parasite occurs in sufficient numbers to warrant attention are the cod, dab (flounder) and grey sole. The percentage of fish infected is much higher in fish taken in inland waters. The fact that the distribution of the harbor and grey seal, which are the source of worms, is mainly in inshore waters, accounts for the high incidence of infestation in inshore fish. Infestations are seemingly more numerous in the spring and summer months, although the larval worm may be found in fish at any time of the year. Although the worm larva may often be readily seen on the cut surface of the fish fillet, the most practical method of detection is by candling of the fish fillet just before they enter the brine tanks. This is accomplished by placing the fillet on a glass surface under which a light is placed so that it shines up through the fillet showing up the worms as a dark area in the fillet. Infested fillets may be removed from the line or the worm may be cut out and the fillet packaged, provided the removal process does not mutilate the fillet to any extent. Occasionally some fillets are processed that are mildly infested with parasites and destination inspectors have reported tapeworm cysts in cod and dab fillets. This is usually an error in nomenclature, as it is believed they refer to the 'codworm'. This is most regrettable, as the only onchosphers or tapeworm cysts found in fish that are harmful to man are the broad tapeworms, *Diphyllbothrium latum*, found in fresh water fish, which is confined chiefly to the Great Lakes area.

Sphyrion lumpi (redfish parasite, button)

"This parasite is a large copepod, approximately one to four inches long and only the females are found attached to the host fish. Because of the manner in which the parasite attaches itself, i. e., by burrowing into the muscle, and because it digests away the muscle tissue of the host during this burrowing process, considerable damage may result in a heavily infested fillet. In some cases, secondary infections occur in the pocket which the parasite has made, causing abscesses, or tumor-like lesions. The eggs are fertilized by the much smaller male; these hatch into larvae which are free living and which may attach themselves to the same fish or swim free until attaching to another fish. This parasite is practically host specific to the ocean perch, although it may be found in other species. The heaviest infestation is found in fish taken in Maine waters and off the coast of Massachusetts. The percentage of fish infected may vary from one, to as high as twenty percent. Although the parasite itself as found in the fillet is usually large enough to be detected by the visual examination without candling; a good control cannot be maintained unless the fillets are candled, for small forms, or those broken off at the surface, or tumors or abscesses, cannot often be seen unless the fillets are candled. These will show up as a dark area under candling, and they can be cut out and the fillet utilized if the cutting does not mutilate the fillet. All ocean perch purchased by the Armed Forces in this area are candled and hence should be free from parasites." Report by Lt. Colonel Floyd E. Monroe, V. C., Boston, Massachusetts, extracted from Military Veterinary New Notes, No. 9, 10 September 1951.

PREVENTIVE MEDICINE

RESTRICTED

GENERAL COMMENT

The health of the command continued to be excellent.

Unless otherwise indicated, reference to disease and injuries in this publication applies to all Class I and Class II installations, exclusive of Walter Reed Army Hospital. Rates are calculated on the basis of a thousand mean strength per year. Statistics presently reported by Army Medical Service installations do not include Air Force personnel. (See General Data and Admissions Tables on page 16).

The non-effective rate* increased from the August rate of 14.68 to 16.26 for the month of September. Days lost as a result of disease and injury totaled 13,222 during the four week period ending 26 September 1951.

*Non-Effective Rate -- $\frac{\text{Total Days lost} \times 1,000}{\text{No. of Days} \times \text{Average Daily Strength}}$
in Period

Non-Effective rates indicate the average number of patients in hospital or quarters per thousand mean strength during the report period.

The total admission rate** for disease and injury in September was 444.8, compared to 386.7 during August. Total admissions for disease and injury in September was 991. Of this number 831 admissions were for disease and 160 injuries. Fort Myer reported the highest admission rate, and U. S. Army Dispensary, The Pentagon reported the lowest rate during the current month.

**Admission Rates -- $\frac{1,000 \times 365 \times \text{Number of Cases}}{\text{Mean Strength} \times \text{No. of Days in Period}}$

Admission rates show the number of cases per thousand strength that would occur during a year if cases occurred throughout the year at the same rate as in the report period.

September's rate for disease cases is 373.0 for 831 cases. Fort Myer reported the highest admission rate, and All Others reported the lowest rate for disease cases.

An injury admission rate of 71.8 per 1,000 per annum for September was reported. This was an increase over the August rate of 64.8. Fort Belvoir reported the highest rate and U.S. Army Dispensary, The Pentagon reported the lowest rate for injuries.

There were 2 deaths reported during the four week period ending 26 September 1951, by units within the Military District of Washington less Walter Reed Army Hospital.

COMMUNICABLE DISEASE

Common respiratory diseases increased in incidence during the month of September 1951. The rate for the present month is 109.0 compared to the August rate of 90.7. Fort Myer reported the highest rate, and All Others reported the lowest rate. Admission rates for pneumonia (all types) increased during the September report period. The rate being 5.3 compared with the August rate of 3.9. There were cases of scarlet fever reported through the month of September.

No appreciable change was noted in the rate for mumps, tuberculosis, rheumatic fever, and hepatitis during the four week period ending 26 September 1951.

Pertinent statistical tables may be found on pages 17 and 21.

RESTRICTED

RESTRICTED**PREVENTIVE MEDICINE**

GENERAL DATA
4-Week Period Ending 26 September 1951
(Data from DD Forms 442)

STATION	MEAN STRENGTH			Direct Admissions						Non-Effective Rate	Number of Deaths
	Total	White	Negro	All Causes		Disease		Injuries			
				Cases	Rates	Cases	Rates	Cases	Rates		
Fort Belvoir, Virginia	17292	15337	1955	633	477.17	509	383.69	124	93.47	17.20	1
Fort McNair, Wash, DC	898	829	69	29	420.95	26	277.41	3	43.55	14.83	0
Fort Myer, Virginia	3923	3768	155	145	481.79	127	421.98	18	59.81	14.00	0
US Army Dispensary The Pentagon	4009	3995	14	105	341.40	100	325.14	5	16.26	21.01	1
All Others	2915	2909	6	79	353.26	69	308.55	10	44.72	7.65	0
Total - Military Dist. of Washington	29037	26838	2199	991	444.87	831	373.04	160	71.83	16.26	2
AMC - Med Detach. (Duty Pers)	1598	1462	136	72	587.30	68	554.70	4	32.60	24.40	0

ADMISSIONS, SPECIFIED DISEASES - RATE PER 1000 PER YEAR
4-Week Period Ending 26 September 1951
(Data from DD Forms 442)

STATION	Common Respiratory Diseases	Pneumonia All Types	Pneumonia Atypical	Measles	Mumps	Scarlet Fever	Tuberculosis	Rheumatic Fever	Hepatitis	Malaria	Influenza	Psychiatric Disease
Fort Belvoir, Va.	104.03	7.54	3.02	-	.75	-	-	1.51	.75	-	3.02	7.54
Fort McNair, Wash, DC	101.61	-	-	-	-	-	-	-	-	24.03	-	-
Fort Myer, Virginia	152.84	3.32	3.32	-	-	-	-	-	-	-	-	3.32
US Army Dispensary The Pentagon	133.31	3.25	-	-	-	-	-	-	-	-	-	-
All Others	49.19	-	-	-	4.47	-	-	-	-	-	8.94	-
Total-Military Dist. of Washington	109.09	5.39	2.44	-	.90	-	-	.90	.45	-	2.69	4.94
AMC-Medical Detach. (Duty Pers)	154.90	-	-	-	-	-	-	-	-	-	-	-

* * * * *

"It has afforded me first as Eighth Army Commander and later as Commander-in-Chief of the Far East Command, the greatest satisfaction to witness what the combination of selfless devotion to duty, professional skill and able administration can effect for the good of the personnel of many services and of many Nations. Unique among America's wars, the Korean conflict has seen no epidemics on our side of any disease against which we have prophylactic defense (though the enemy has not escaped). The death rate in our hospitals is by far the lowest ever known in war. Our medical soldiers have gallantly and at the risk of their own lives, saved those of their armed comrades, being skillfully led by devoted medical officers. Our senior medical officers have never spared themselves, but have personally directed evacuation of our wounded under conditions fraught with extreme danger and difficulty."

General Matthew B. Ridgway

RESTRICTED

PREVENTIVE MEDICINE

RESTRICTED

VENEREAL DISEASE

Venereal Disease rate among units within the Military District of Washington, decreased during the September report period.

The rate for September 1951, was 14.37, a decrease from the August rate of 16.31. A total of 32 cases were reported for the four week period ending 26 September 1951. Of this total 24 were reported by Fort Belvoir, 7 cases for Fort Myer and 1 case for All Others.

During the report period, White personnel incurred 15 of the reported number of cases, with a rate of 7.29 and 17 were incurred by Negro personnel with a resulting rate of 100.77 per 1000 troops per annum.

In order to enable non-professional personnel to more intelligently understand the rates of cases to personnel on duty at each designated station, we have undertaken to report the number of cases per 1000 men for this report period (September) in addition to the rate per 1000 per annum which is not always clearly understood and is often misinterpreted.

Pertinent statistical tables and charts may be found on pages 18 and 19

NEW VENEREAL DISEASE CASES - EXCL EPTS - JULY, AUGUST AND SEPTEMBER 1951

STATION	Rate per 1000 per year	Rate per 1000 per year	Rate per 1000 per year	Cases per 1000 Troops
	JULY 1951	AUGUST 1951	SEPTEMBER 1951	SEPTEMBER 1951
Fort Belvoir	33.41	24.69	18.09	1.387
Fort McNair	-	23.94	-	-
Fort Myer	6.14	5.12	23.26	1.784
U.S. Army Dispensary, Pentagon	-	-	-	-
All Others	5.06	-	4.47	.343
Total - Military District of Washington Units	21.01	16.31	14.37	1.102
Army Medical Center - Medical and Holding Detachments	11.69	25.66	12.27	.941
Total - Dept/Army Units Military Dist/Wash	20.05	17.24	14.06	1.078
	*	*	*	*

ARMY HEALTH RECORD HIGH

Despite the Korean war and the rapid expansion of the Army, the Army's health was better in 1950 than in two of the four post-World War II years. The average daily percentage of personnel unavailable for duty during 1950, either from hospitalization or other medical restriction, was 2.8. This included battle wounds and injuries. For the years 1946 and 1947 the percentages were 4.1 and 3.6 respectively. The 1950 figure was a close third to what the Army considers its healthiest two years in history, 1948 and 1949. During these years the percentage figures were 2.6 and 2.2 respectively.

(The above is from Report to the Army, September 1951)

RESTRICTED

PREVENTIVE MEDICINE

RESTRICTED

CHART 1

ADMISSION RATES BY MONTH, ALL CAUSES, COMMON RESPIRATORY DISEASE AND INJURY
MDW RATE PER 1000 TROOPS PER YEAR

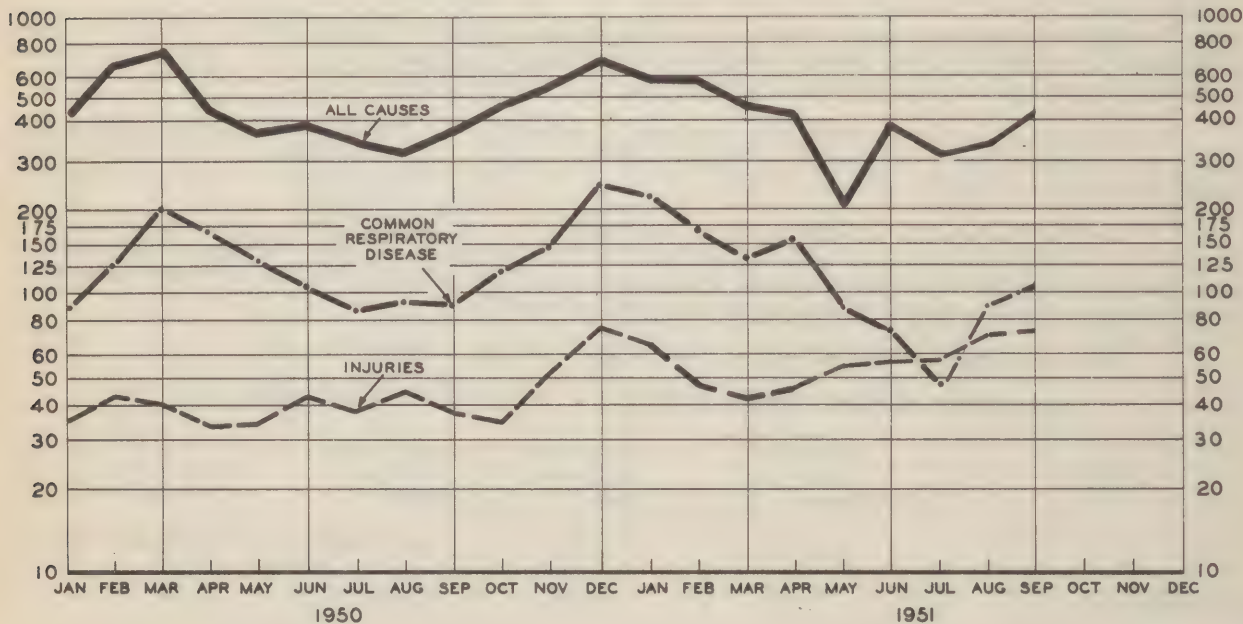
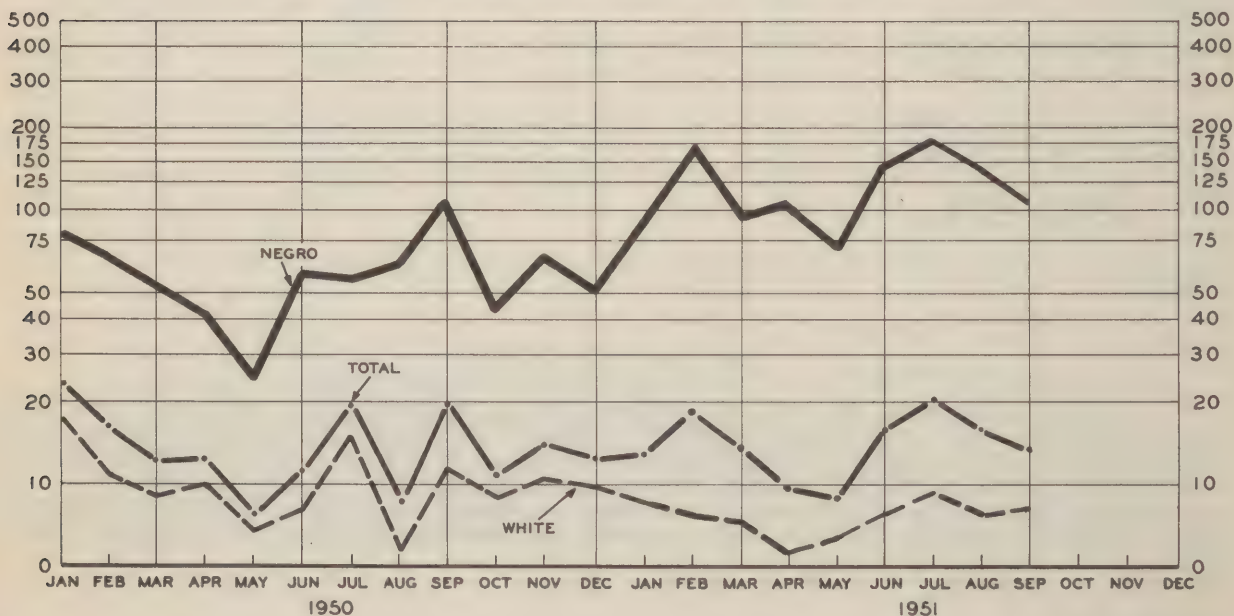


CHART 2

ADMISSION RATES BY MONTH VENEREAL DISEASES MDW NOT INCL. ARMY MEDICAL CENTER
RATES PER 1000 TROOPS PER YEAR
INCLUDES ALL CASES REPORTED ON WD AGO 8-122 EXCEPTING THOSE EPTS

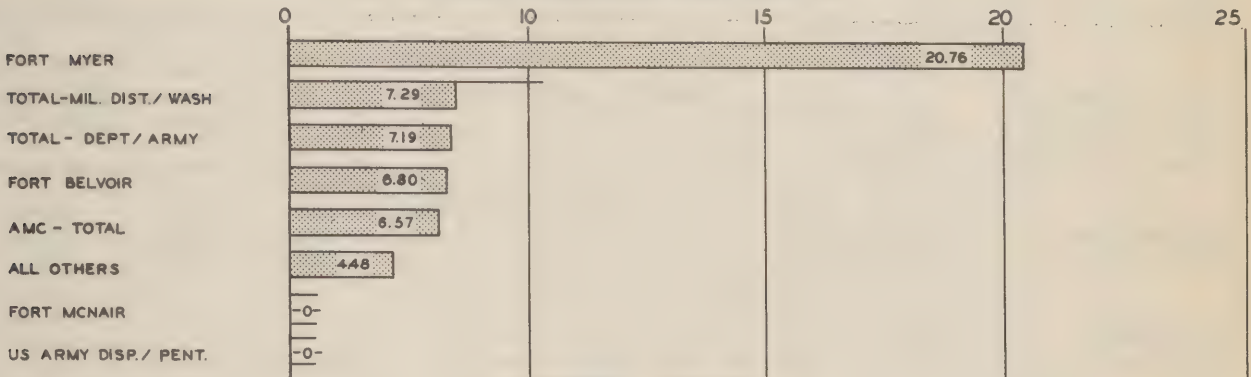


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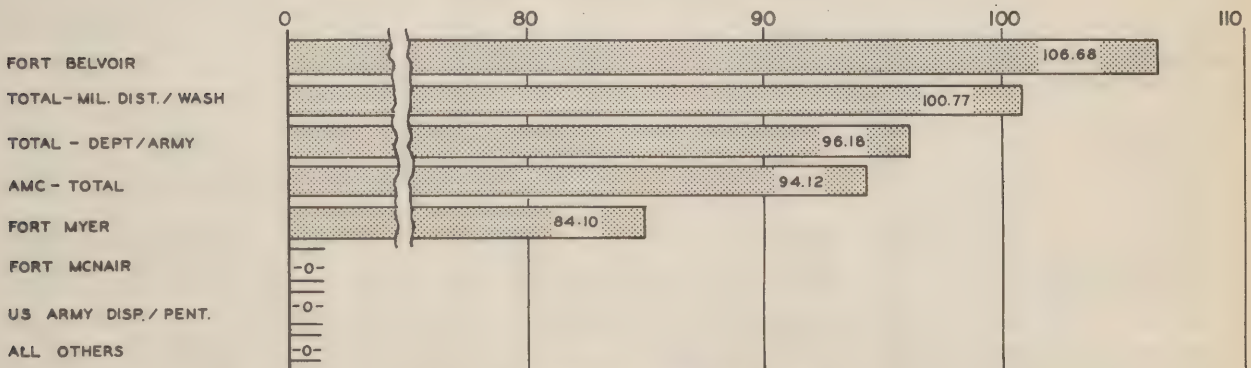
PREVENTIVE MEDICINE

RESTRICTED

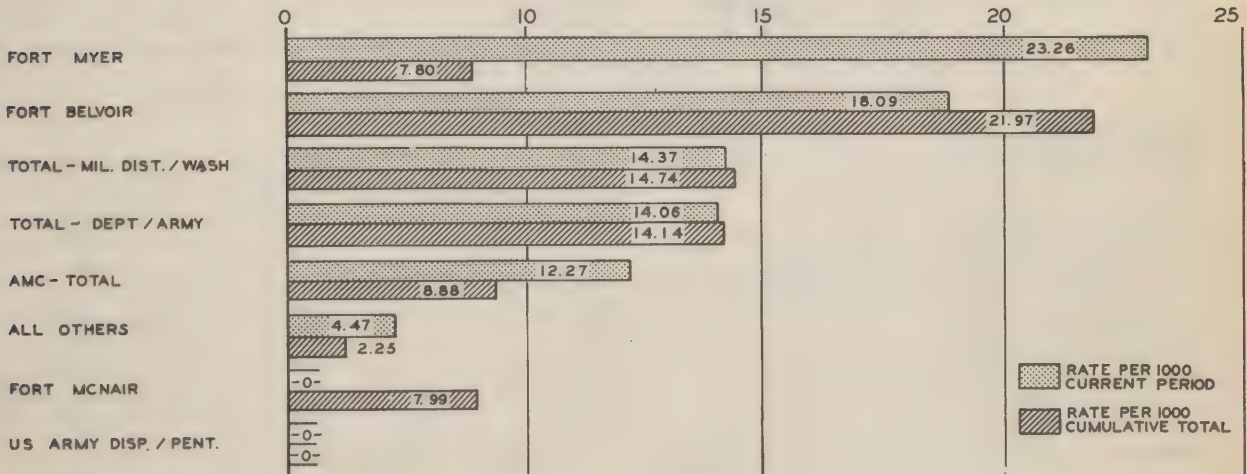
VENEREAL DISEASE
RATE PER 1000 TROOPS PER YEAR
4 WEEK PERIOD ENDING 26 SEP 1951
WHITE PERSONNEL (CHARGEABLE CASES)



VENEREAL DISEASE
RATE PER 1000 TROOPS PER YEAR
4 WEEK PERIOD ENDING 26 SEP 1951
NEGRO PERSONNEL (CHARGEABLE CASES)



VENEREAL DISEASE
RATES PER 1000 PER YEAR
FOUR WEEK & CUMULATIVE TOTALS ENDING 26 SEP 1951
TOTAL WHITE & NEGRO PERSONNEL (CHARGEABLE CASES)



RATE PER 1000
CURRENT PERIOD
 RATE PER 1000
CUMULATIVE TOTAL

RESTRICTED

RESTRICTED**PREVENTIVE MEDICINE****CONSOLIDATED MONTHLY VENEREAL DISEASE STATISTICAL REPORT**

For the Four Week Period Ending 26 September 1951

(Data from DD Forms 442) (Chargeable Cases)

STATION	R A C E	Mean Strength	Syphilis	Gonorrhea	Other	Total	Rate Per 1000 Troops per Annum	Total Days Lost From Duty (Old & New Cases)
Fort Belvoir	W	15337	1	7	0	8	6.80	.521
	N	1955	0	15	1	16	106.68	8.184
	T	17292	1	22	1	24	18.09	1.387
Fort McNair	W	829	0	0	0	0	-	-
	N	69	0	0	0	0	-	-
	T	898	0	0	0	0	-	-
Fort Myer	W	3768	0	6	0	6	20.76	1.592
	N	155	0	1	0	1	84.10	6.451
	T	3923	0	7	0	7	23.26	1.784
US Army Dispensary The Pentagon	W	3995	0	0	0	0	-	-
	N	14	0	0	0	0	-	-
	T	4009	0	0	0	0	-	-
All Others	W	2909	0	1	0	1	4.48	.343
	N	6	0	0	0	0	-	-
	T	2915	0	1	0	1	4.47	.343
Total-Military District of Washington	W	26838	1	14	0	15	7.29	.558
	N	2199	0	16	1	17	100.77	7.730
	T	29037	1	30	1	32	14.37	1.102
Army Medical Center	W	3971	1	1	0	2	6.57	.503
	N	277	0	2	0	2	94.12	7.220
	T	4240	1	3	0	4	12.27	.941
Total-Depot/Army Units	W	30809	2	15	0	17	7.19	.551
	N	2575	0	18	1	19	96.18	7.378
	T	33384	2	33	1	36	14.06	1.078

VENEREAL DISEASE RATES*

(All Army Troops)

JULY 1951**AUGUST 1951****SEPTEMBER 1951**

First Army Area
Second Army Area
Military District of Washington
Third Army Area
Fourth Army Area
Fifth Army Area
Sixth Army Area

31
28
20
32
39
24
41

39
27
17
26
35
28
40

42
28
14
26
38
29
38

TOTAL United States

32

31

32

*Compiled in the Office of the Surgeon General and Includes US Army Hospitals.

RESTRICTED

DENTAL SERVICE

RESTRICTED

DENTAL SERVICE - FOUR WEEK PERIOD ENDING 26 SEPTEMBER 1951

STATION	Total Officer	Dentist Civilian	Sit- tings	Out- Patient Service	Total Fill- ings	Total Bridge	Crowns	Total Dentures	Calculus Removed	Extracts	Roentgen- ograms	Exams
Fort Belvoir	31	1	7497	1029	4285	21	9	117	413	1597	1891	6579
Fort McNair	2	0	199	23	128	0	0	5	16	50	110	40
Fort Myer, Va.	5	1	1758	277	698	2	7	30	180	185	747	613
US Army, Disp- ensary, Pent.	8	0	1841	0	704	8	0	32	89	168	638	627
All Others	4	0	999	65	450	1	1	4	35	130	175	562
Total - MDW	50	2	12294	1394	6265	32	17	188	733	2130	3561	8421

VETERINARY SERVICE

POUNDS MEAT AND MEAT FOOD AND DAIRY PRODUCTS INSPECTED SEPTEMBER 1951
(Data obtained from WD AGO Forms 8-134)

STATION	CLASS * 3	CLASS * 4	CLASS * 5	CLASS * 6	CLASS * 7	CLASS * 8	CLASS * 9	TOTAL
Fort Lesley J. McNair		60,401	121,005		184,334		54,567	420,307
Fort Belvoir, Virginia		586,930	294,512		947,890	171,882	381,906	2,383,120
Alexandria Field Buying Office		410,180	322,771	688,847			135,894	1,557,692
Fort Myer, Virginia		117,609	148,951	558	304,267	5,068	130,672	707,125
Cameron Station, Virginia		157,815	165,259	2,421	291,617	7,155	97,687	721,954
MDW Veterinary Detachment	696,720							696,720
The Pentagon							293,177	293,177
Army Medical Center		181,038	160,508		336,096	13,458	62,324	753,424
TOTAL	696,720	1,513,973	1,213,006	691,826	2,064,204	490,740	863,050	7,533,519
REJECTIONS:								
Not type class or grade								
Alex. Field Buying Off.		18,951						18,951
Cameron Station, Va.		225						225
MDW Veterinary Detachment	2,755							2,755
Insanitary or Unsound								
Alex. Field Buying Off.		311						311
Fort Myer, Virginia						60		60
MDW Veterinary Detachment	1,405							1,405
TOTALS	4,160	19,487				60		23,707

*Class 3 - Prior to Purchase
*Class 4 - On delivery at Purchase
*Class 5 - Army Receipt except Purchase
*Class 6 - Prior to Shipment

*Class 7 - At Issue
*Class 8 - Purchase by Post Exchange, Clubs
 Messes or Post Restaurants
*Class 9 - Storage

OUTPATIENT SERVICE

OUTPATIENT SERVICE

Consolidated statistical data on outpatient service, Military District of Washington, less Walter Reed Army Hospital, are indicated below for the four week period ending 26 September 1951:

ARMY:

Number of Outpatients 16443
Number of Treatments 20806

NON-ARMY:

Number of Outpatients 15503
Number of Treatments 17365

NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED 1401

NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED 11740

HOSPITAL MESS ADMINISTRATION

HOSPITAL MESS ADMINISTRATION

STATION	JUNE 1951	JULY 1951	AUGUST 1951	SEPTEMBER 1951
Fort Belvoir				
Income per Ration	\$1.3178	\$1.3327	\$1.3455	\$1.353
Expense per Ration	1.2453	1.2586	1.2556	1.333
Gain or Loss	+.0725	+.0741	+.0900	+.020

RESTRICTED

CIVILIAN EMPLOYEES HEALTH SERVICE PROGRAM

DIABETES

By

A. A. Friedman, M.D.

Among the many diseases to which people have a hereditary tendency, diabetes or as it is more commonly known "sugar diabetes", is one of the most easily discovered. Why do we want to discover it? The answer is simple. The treatment of diabetes, in many instances, is relatively easy. By proper treatment, the early and late complications of diabetes may be prevented or minimized. As a result of this, a longer life span may be anticipated by the patient.

How can it be diagnosed? In many cases the diagnosis may be made merely by examining the urine, in which case sugar is found to be present. In some instances there may be no other symptoms associated with the presence of sugar in the urine. On the other hand, weight loss, excessive appetite, excessive thirst and the production of large quantities of urine may occur, either singly or in any combinations of symptoms.

During the week of November 11 to 17 inclusive, there will be a national wide survey in an attempt to bring to light individuals whose diabetes is so very mild as to be asymptomatic or has not yet been discovered. It has been estimated that there are approximately three-fourths of a million such cases in the United States. This investigation is being sponsored by the American Diabetes Association and supported by the Department of Defense, Civilian Employee Health Service Program in the metropolitan area of Washington.

Details as to collection of samples, notifying private physicians will be published and made available to Department of Defense, civilian employees within the near future.

* * *

THE EYES HAVE IT!

Your eyes work as hard or harder than any other part of your body. Each eye has eight muscles, and each muscle works all the time that you are awake. Those eyes of yours are small and very delicate, yet they put in a long and hard work shift every day of your life. Your work--your health, and the health of those around you--your take home pay--are all affected by your vision.

Your eye is like a camera: Just as a camera works in taking a picture, so do your eyes "take a picture" every time you look at and see something. There are many things which can make your "camera" take pictures which are out of focus or blurred. And when your eyes are tired and don't work well, your whole body is affected. Headaches, fatigue, upset stomach, dizziness, and many other serious general body complaints can each and all arise from poor vision. Some conditions which can make your "camera" work poorly are near and far sightedness, astigmatism, and far sightedness that comes as a natural process as we grow older. These can be readily corrected by glasses fitted to the eyes by a trained physician. You can't buy just any pair of glasses and expect them to help your eyes.

Can your eyes be helped? Your eyes can be helped both by you and by the conditions under which you use them. Helping your eyes and helping your working conditions is a job for experts. Your eyes can be examined for disease or for glasses. Disease, infection, eyestrain can be recognized and helped by an Eye Doctor. Most people do not need glasses. This is a job for specially trained personnel to determine: your Ophthalmologist and your Optometrist.

Color and lighting. Good lighting in the workshop is a job that also requires the work of experts. Engineers should inspect the shop for glare, disturbing dark shadows, and the like, and from this, can give advice on how many and what kind of lights your shop needs. Often there is plenty of light which is poorly spaced and thus gives glare and shadow--glare and shadow hurt the eyes and waste electricity. Sometimes a simple thing like cleaning the windows, bulbs and reflectors can make a big improvement in lighting. Painting walls, ceilings, and machines the proper colors is also a great help to vision. It adds light without glare, makes moving parts and work material easier to see.

YOU CAN GET A SET OF FALSE TEETH THAT WILL CHEW
WELL, BUT YOU CANNOT GET A FALSE EYE THAT WILL SEE!



Original painting by Bennett I. Miller, Pvt 2, US-51080410, 7071st ASU (Sta. Med. Act), Medical Company, Fort Belvoir, Virginia